STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 00 B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR CONVALESCENT & REHAB CENTER	3300 POPLAR ST TERRE HAUTE, IN47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00094248 and IN00095253. Complaint IN00094248 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00095253 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, F226, F309, F315 and F505. Survey dates: August 25, 26, 29 and 30, 2011 Facility number: 000249 Provider number: 155358 AIM number: 100267640 Survey team: Kimberly Perigo, RN Census bed type: SNF/NF: 71 Total: 71 Census payor type: Medicare: 07 Medicaid: 50 Other: 14 Total: 71	F0000	Please accept this Revised HCFA Plan of Credible Allegation of compliance.Meadows Manor has always and will continue to comply with all State and Federal Regulations. This survey does not reflect the actual care given to all residents of the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0223 SS=D	Sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/07/11 by Suzanne Williams, RN The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interviews and record reviews, the facility failed to ensure a resident had been free from mistreatment and/or abuse for 1 of 1 allegation of staff to resident abuse reviewed in a sample of 11 residents. (Resident H) Findings include: Interview on August 25, 2011 at 3:25 p.m.; with RN #3 indicated a known incident which had occurred on the night shift [unknown date] and involved Resident H and CNA #4. Interview on August 26, 2011 at 2:30 a.m.; with RN #5 indicated a known incident which had occurred on the night shift of August 03, 2011; which involved Resident H and CNA #4. The incident	F0223	Meadows Manor East has never nor would we ever knowingly hire anyone who has been guilty or even accused of any sort of abuse. All employees receive a local and state criminal check, all references checked, and the State CNA Registry is checked to see if there are any allegations, and if the CNA is in good standing with an active certification. All these checks were done on CNA #4. Also all employees are given a copy of the abuse policy and resident rights in orientation before they are allowed on the floor to work. This CNA was a new employee of two days and was told to leave the facility on the day of the incident, with termination the next day by the D.O.N. He had no contact with resident H after occurrance. As CNA #6 said in survey, "resident H did not yell, did not indicate being hurt, nor did	09/16/2011

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	was witnessed by CNA #6 and reported to RN #7. RN #5 further indicated CNA #4 had been sent home during the shift and later terminated. On August 29, 2011, the Director of Nursing provided a copy of an Incident Report dated August 03, 2011 at 4:30 a.m. A statement provided by CNA #6 to the nursing facility indicated; "On 8-3-11 about 4:30 am[CNA #4's name] and I went into get [Resident H's name] dressed. We turned him to me first and [CNA #4's name] washed his bottom and put the brief under him, then we turned him to [CNA #4's name]. [Resident H's name] said what the h--- you doin. I said we are getting you dressed he started punching [CNA #4's name]. [CNA #4's name] grabbed his fist and started squezzing [sic] [Resident H's name] hands harder and harder. I said you need to walk away. [CNA #4's name] turned and hit the wall and started growling and I said you need to go answer [other resident's name] light. He walked out and I finished getting [Resident H's name] dressed with no problem. [sic]" CNA #6 was interviewed on August 29, 2011 at 1:34 p.m. During the interview CNA #6 indicated her statement was correct. CNA #6 had indicated, after		she see any change of color to resident H's hands." An incident report was done, which follows the resident's condition for seventy-two hours after the incident. There was no complications for this resident.To prevent a reoccurrance of this F-tag, an inservice on abuse was held on 9-15-11 (see attached #1). This, as well as all the above mentioned steps, will prevent resident H, and all present or future residents from having a reoccurrance.Monitored by: Administrator, D.O.N., Inservice Director, and Q.A. Committee***REVISIONAdministrator was notified of this incident in a timely manner, however, failed to notate this in the Plan of Correction. All allegations of abuse are investigated thoroughly, and brought to the monthly Q.A. Meeting. Social Services will do random weekly random checks and if any questionable allegations she will report immediately to Administrator all residents interviewed willl be brought to the next morning meetings. Monitored by: Administrator, D.O.N. Social Services, and Q. A. Committee	

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	asked, Resident H was observed to be trying to free his hands while being squeezed. Resident H did not yell, did not indicate being hurt, nor did she see any change of color to Resident H's hands. After having completed Resident H's care, CNA #6 left the room and reported the observed incident to RN #7. A statement provided by RN #7 to the nursing facility indicated; "8-3-11 At about approx 4:30 AM I was in the hallway on West Wing and [CNA #6's name] yelled out my name. ... She told me that there was a problem with [CNA # 4's name], the new [CNA #6's name] stated that while she and [CNA #4's name] were providing AM care for a resident, she observed [CNA #4's name] putting his hands over the resident's hands which were doubled up and [CNA #4's name] was squeezing the resident's hands. [CNA #6's name] told [CNA #4's name] to step away from the resident and she would finish dressing him. [CNA #4's name] stepped away hit the wall with his fist and put his head against the wall. [CNA #6's name] then told him he needed to leave the room several times. [CNA #4's name] then left and [CNA #6's name] came to tell me. [CNA #4's name] was at the Nurses Station while [CNA #6's name] and I talked. [sic]"			

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	A statement provided by RN #7 to the nursing facility indicated; "8-3-11 At approx. 4:30 AM I approached [CNA #4's name] at East Wing Nurses Station and told him I need to talk with him, that I heard that he was upset. ... I asked [CNA #4's name] what he was upset about and he said that during AM care the resident kicked him with his foot. I asked [CNA #4's name] if he was holding the residents hands and he replied that he was holding them. I said it was reported that he was squeezing the resident's hands. He replied that he was because when he get hit in the face that it's his 'trigger point,' that the last time he was hit in the face he kept control and was able to walk out of the room. I asked, 'then this has happened before ?' He replied yes. I observed [CNA #4's name] clenching and unclenching his fist, his head jerking to the side and profuse sweating while he was talking with me. I asked [CNA #4's name] if he had hit the wall with his fist and he replied 'No.' I told him it was reported that he did. He replied that he may have put his hand against the wall harder than he intended. I told [CNA #4's name] that regulations and policy states that he will have to clock out ... [sic]" CNA #4's personnel records were reviewed on August 29, 2011 at 1:50 p.m. An Employee Termination Notification			

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	dated August 04, 2011; and signed by the Director of Nursing had indicated "Resident Abuse 8/3/11. Summary: Holding and squeezing resident's hands while giving ADL [activities of daily living] care and when asked to leave the room, hit the wall with fist and growled on the way out the door. Told Supervisor that held resident's hand and hit wall hard. Stated 'when I get hit in my face that is my trigger point.' " The Director of Nursing was interviewed on August 29, 2011 at 2:15 p.m. During the interview, the Director of Nursing indicated CNA #4 was terminated, due to resident abuse. This deficiency is related to Complaint IN00095253. 3.1-27(a)(1)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interviews and record reviews, the facility failed to ensure an observed incident of resident mistreatment was immediately reported and the facility and failed to ensure prevention of further	F0225	CNA #4 received all criminal checks, reference checks, and was checked on the State CNA Registry. There was no indication anywhere that this employee was capable or had done this	09/16/2011

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	potential mistreatment and/or abuse by not having immediately removed the identified staff, for 1 of 1 allegation of staff to resident abuse reviewed in a sample of 11 residents. (Resident H) Findings include: Interview on August 25, 2011 at 3:25 p.m.; with RN #3 indicated a known incident which had occurred on the night shift [unknown date] and involved Resident H and CNA #4. Interview on August 26, 2011 at 2:30 a.m.; with RN #5 indicated a known incident which had occurred on the night shift of August 03, 2011; which involved Resident H and CNA #4. The incident was witnessed by CNA #6 and reported to RN #7. RN #5 further indicated CNA #4 had been sent home during the shift and later terminated and that RN #7 was also no longer employed. On August 29, 2011, the Director of Nursing provided a copy of an Incident Report dated August 03, 2011 at 4:30 a.m. A statement provided by CNA #6 to the nursing facility indicated; "On 8-3-11 about 4:30 am[CNA #4's name] and I went into get [Resident H's name] dressed. We turned him to me first and		allegation in the past. Meadows Manor would not have hired him or anyone else if these checks were not completely without allegations. We also give an Abuse, and Resident Rights policy to every new hire before they are allowed to work on the floor. They are also given the policy on how to report any seen or suspicious activity/behavior of a staff member (see attached #1). CNA #6 did tell CNA #4 to leave the room, but failed to go immediately to her supervisor. She continued with her resident. CNA #6 did receive a verbal warning for this offense. (see attached #2). RN #7 also failed to follow procedure, which is to escort the accused employee out of the facility immediately. She called the D.O.N. to advise her of the incident, instead of following procedure, and then notifying D.O.N. RN #7 was the previous D.O.N., so she knew the policy well. She had to have others sent home pending investigation on previous occasions. Employee #4 was escorted out, but not immediately. He was terminated the next day. Because of her knowledge and number of years working not only as the DON, but a floor supervisor and charge nurse in the facility, she received a written warning and suspension (see attached #3). To prevent resident H, as well as present and future residents from having this F-tag reoccur, an inservice was	

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	[CNA #4's name] washed his bottom and put the brief under him, then we turned him to [CNA #4's name]. [Resident H's name] said what the h--- you doin. I said we are getting you dressed he started punching [CNA #4's name]. [CNA #4's name] grabbed his fist and started squezzing [sic] [Resident H's name] hands harder and harder. I said you need to walk away. [CNA #4's name] turned and hit the wall and started growling and I said you need to go answer [other resident's name] light. He walked out and I finished getting [Resident H's name] dressed with no problem. [sic]" CNA #6 was interviewed on August 29, 2011 at 1:34 p.m. During the interview CNA #6 indicated her statement was correct. CNA #6 had indicated, after asked, Resident H was observed to be trying to free his hands while being squeezed. Resident H did not yell, did not indicate being hurt, nor did she see any change of color to Resident H's hands. After having completed Resident H's care, CNA #6 left the room and reported the observed incident to RN #7. A statement provided by RN #7 to the nursing facility indicated; "8-3-11 At about approx 4:30 AM I was in the hallway on West Wing and [CNA #6's name] yelled out my name. ... She told me		held on 9-15-11 (see attached #1).Monitored by: Administrator, D.O.N., Inservice Director, and Q.A. Committee.***REVISIONAdministrator was notified of incident as per faciliy policy. Abuse policy has been reviewed and will continued to be reviewed every 6 months and revised as needed. Administrator was notified of this incident in a timely manner, but failed to include this in the Plan of Correction. Administrator and D.O.N will ask reporting staff member if the alleged staff member has been escorted from the building. All allegations of abuse are investigated thoroughly, and reported to all state authorities as required. Monitored by: Administrator, D.O.N., Inservice Director, and Q.A. Committee	

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	that there was a problem with [CNA # 4's name], the new [CNA #6's name] stated that while she and [CNA #4's name] were providing AM care for a resident, she observed [CNA #4's name] putting his hands over the resident's hands which were doubled up and [CNA #4's name] was squeezing the resident's hands. [CNA #6's name] told [CNA #4's name] to step away from the resident and she would finish dressing him. [CNA #4's name] stepped away hit the wall with his fist and put his head against the wall. [CNA #6's name] then told him he needed to leave the room several times. [CNA #4's name] then left and [CNA #6's name] came to tell me. [CNA #4's name] was at the Nurses Station while [CNA #6's name] and I talked. [sic]" A statement provided by RN #7 to the nursing facility indicated; "8-3-11 At approx. 4:30 AM I approached [CNA #4's name] at East Wing Nurses Station and told him I need to talk with him, that I heard that he was upset. ... I asked [CNA #4's name] what he was upset about and he said that during AM care the resident kicked him with his foot. I asked [CNA #4's name] if he was holding the residents hands and he replied that he was holding them. I said it was reported that he was squeezing the resident's hands. He replied that he was because when he get hit in the			

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	face that it's his 'trigger point,' that the last time he was hit in the face he kept control and was able to walk out of the room. I asked, 'then this has happened before ?' He replied yes. I observed [CNA #4's name] clenching and unclenching his fist, his head jerking to the side and profuse sweating while he was talking with me. I asked [CNA #4's name] if he had hit the wall with his fist and he replied 'No.' I told him it was reported that he did. He replied that he may have put his hand against the wall harder than he intended. I told [CNA #4's name] that regulations and policy states that he will have to clock out ... [sic]" A second statement provided by CNA #6 to the nursing facility indicated, "It took me about 5 to 7 mins. to get [Resident H's name] dressed cause he was calmer when [CNA #4's name] walk out. ... He took the trash and linens to the soiled room ... I told [CNA #4's name] to leave about 4:20 and I left about 4:30 told the supervisor about 4:40. [sic]" CNA #4's time record indicated on the morning of August 03, 2011 he clocked out to leave the nursing facility at 5:06 a.m. CNA #4's personnel records were reviewed on August 29, 2011 at 1:50 p.m.			

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	An Employee Termination Notification dated August 04, 2011; and signed by the Director of Nursing had indicated "Resident Abuse 8/3/11. Summary: Holding and squeezing resident's hands while giving ADL [activities of daily living] care and when asked to leave the room, hit the wall with fist and growled on the way out the door. Told Supervisor that held resident's hand and hit wall hard. Stated 'when I get hit in my face that is my trigger point.' " The Director of Nursing was interviewed on August 29, 2011 at 2:15 p.m. During the interview, the Director of Nursing indicated CNA #4 was terminated, due to resident abuse. The Director of Nursing indicated CNA #6 did not immediately report her observation, and RN #7 did not immediately remove CNA #4 from the building to prevent further potential abuse. This deficiency is related to Complaint IN00095253. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			

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	Based on interviews and record reviews, the facility failed to ensure an allegation of resident mistreatment was immeditately reported and the identifed employee had been immediately removed to prevent further resident mistreatment, according to the facility's abuse prevention policy and procedures, for 1 of 1 allegation of staff to resident abuse reviewed in a sample of 11. (Resident H) Findings include: Interview on August 25, 2011 at 3:25 p.m.; with RN #3 indicated a known incident which had occurred on the night shift [unknown date] and involved Resident H and CNA #4. Interview on August 26, 2011 at 2:30 a.m.; with RN #5 indicated a known incident which had occurred on the night shift of August 03, 2011; which involved Resident H and CNA #4. The incident was witnessed by CNA #6 and reported to RN #7. RN #5 further indicated CNA #4 had been sent home during the shift and later terminated and that RN #7 was also no longer employed. On August 29, 2011, the Director of Nursing provided a copy of an Incident Report dated August 03, 2011 at 4:30 a.m.	F0226	Meadows East has and follows it's abuse/neglect policy. This tag occurred because two employees did not follow the policy in a timely manner. CNA #6 did follow procedure in telling CNA #4 to leave the room, but finished with her resident before reporting to her supervisor. RN #7 called her D.O.N. before removing CNA #4 from the facility. As stated by surveyor's statement, RN #7 quoted the policy to CNA #4. This proves there is a policy in place, and the staff knows it. Also, the surveyor said the D.O.N. presented her with the policy. Both of these employees were reprimanded for their actions (see attached #'s 2 & 3). To prevent a reoccurrance of this F-tag, an inservice on reporting any allegations of abuse was held on 9-15-11 (see attached #1). This will ensure that resident H, and all other residents will not have a delay in reporting again. Monitored by: Administrator, D.O.N., Inservice Director, and Q.A. Committee***REVISIONAdministrator and D.O.N. will inquire at time of notification if alleged employee has been escorted from the building. Also Administrator and D.O.N. will interview or get statements from all persons involved to ensure procedures were followed correctly. Any allegations will be reviewed within 24 hours to ensure procedure was	09/16/2011

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	155358	A. BUILDING 00 B. WING	08/30/2011

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	A statement provided by CNA #6 to the nursing facility indicated; "On 8-3-11 about 4:30 am[CNA #4's name] and I went into get [Resident H's name] dressed. We turned him to me first and [CNA #4's name] washed his bottom and put the brief under him, then we turned him to [CNA #4's name]. [Resident H's name] said what the h--- you doin. I said we are getting you dressed he started punching [CNA #4's name]. [CNA #4's name] grabbed his fist and started squezzing [sic] [Resident H's name] hands harder and harder. I said you need to walk away. [CNA #4's name] turned and hit the wall and started growling and I said you need to go answer [other resident's name] light. He walked out and I finished getting [Resident H's name] dressed with no problem. [sic]" CNA #6 was interviewed on August 29, 2011 at 1:34 p.m. During the interview CNA #6 indicated her statement was correct. CNA #6 had indicated, after asked, Resident H was observed to be trying to free his hands while being squeezed. Resident H did not yell, did not indicate being hurt, nor did she see any change of color to Resident H's hands. After having completed Resident H's care, CNA #6 left the room and reported the observed incident to RN #7.		followed. D.O.N. will track all allegations and will meet with Administrator, Social Services and A.D.O.N. weekly. All incident reports will be investigated thoroughly and brought to monthly Q.A. Meetings for further evaluation.Monitored by: Administrator, Social Services and A.D.O.N.	

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	A statement provided by RN #7 to the nursing facility indicated; "8-3-11 At about approx 4:30 AM I was in the hallway on West Wing and [CNA #6's name] yelled out my name. ... She told me that there was a problem with [CNA # 4's name], the new [CNA #6's name] stated that while she and [CNA #4's name] were providing AM care for a resident, she observed [CNA #4's name] putting his hands over the resident's hands which were doubled up and [CNA #4's name] was squeezing the resident's hands. [CNA #6's name] told [CNA #4's name] to step away from the resident and she would finish dressing him. [CNA #4's name] stepped away hit the wall with his fist and put his head against the wall. [CNA #6's name] then told him he needed to leave the room several times. [CNA #4's name] then left and [CNA #6's name] came to tell me. [CNA #4's name] was at the Nurses Station while [CNA #6's name] and I talked. [sic]" A statement provided by RN #7 to the nursing facility indicated; "8-3-11 At approx. 4:30 AM I approached [CNA #4's name] at East Wing Nurses Station and told him I need to talk with him, that I heard that he was upset. ... I asked [CNA #4's name] what he was upset about and he said that during AM care the resident kicked him with his foot. I asked [CNA			

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	#4's name] if he was holding the residents hands and he replied that he was holding them. I said it was reported that he was squeezing the resident's hands. He replied that he was because when he get hit in the face that it's his 'trigger point,' that the last time he was hit in the face he kept control and was able to walk out of the room. I asked, 'then this has happened before ?' He replied yes. I observed [CNA #4's name] clenching and unclenching his fist, his head jerking to the side and profuse sweating while he was talking with me. I asked [CNA #4's name] if he had hit the wall with his fist and he replied 'No.' I told him it was reported that he did. He replied that he may have put his hand against the wall harder than he intended. I told [CNA #4's name] that regulations and policy states that he will have to clock out ... [sic]" A second statement provided by CNA #6 to the nursing facility indicated, "It took me about 5 to 7 mins. to get [Resident H's name] dressed cause he was calmer when [CNA #4's name] walk out. ... He took the trash and linens to the soiled room ... I told [CNA #4's name] to leave about 4:20 and I left about 4:30 told the supervisor about 4:40. [sic]" CNA #4's time record indicated on the morning of August 03, 2011 he clocked			

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	out to leave the nursing facility at 5:06 a.m. CNA #4's personnel records were reviewed on August 29, 2011 at 1:50 p.m. An Employee Termination Notification dated August 04, 2011; and signed by the Director of Nursing had indicated "Resident Abuse 8/3/11. Summary: Holding and squeezing resident's hands while giving ADL [activities of daily living] care and when asked to leave the room, hit the wall with fist and growled on the way out the door. Told Supervisor that held resident's hand and hit wall hard. Stated 'when I get hit in my face that is my trigger point.' " The Director of Nursing was interviewed on August 29, 2011 at 2:15 p.m. During the interview, the Director of Nursing indicated CNA #4 was terminated, due to resident abuse. On August 29, 2011, the Director of Nursing provided a copy of the nursing facility's Abuse Prevention Program Policies and Procedures [non-dated] which indicated, "Policy Statement: It is the responsibility of our employees, ... to promptly report any incident or suspected incident of ... resident abuse ... Our facility will not condone resident abuse by anyone, including staff members ... Abuse			

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	is defined as the willful inflicion of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish ... Any individual observing an incident of resident abuse or suspecting resident abuse must promptly report such incident to a member of the nursing staff or to management...." The Director of Nursing was interviewed on August 29, 2011 at 2:15 p.m. During the inteview, the Director of Nursing indicated their Abuse Prevention Program Policies and Procedures had not been followed for the incident dated August 03, 2011 at 4:30 a.m. C.N.A #6 received written discipline due to not having immediately reported her observation. RN #7 received two days suspension due to not having immediately removed CNA #4 from the building to ensure prevention of any further abuse. This deficiency is related to Complaint IN00095253. 3.1-28(a)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interviews and record reviews,	F0309	Resident B did receive an order	09/16/2011

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	the facility failed to ensure prompt implementation of care for a resident diagnosed with a fungal toenail infection (Resident B) for 1 of 1 resident reviewed with a fungal infection of a toenail in the sample of 11 residents. Findings include: Resident B's clinical records were reviewed on August 25, 2011 at 11:45 a.m. Physician's Follow Up Progress Notes dated August 04, 2011; indicated a diagnosis of Fungi toenail [yeast infection]. Physician's Orders dated August 04, 2011 at 6:00 p.m. indicated "A) Fungnail Tincture B) Fungi-nail C) Vicks Vapor Rub - Apply on and around all toenails twice daily for 104 weeks ..." A form, located on the involved resident's clinical record, with the attached Physician's Orders dated August 04, 2011; indicated "We are unsure of what is needed. Could you please clarify the order as to what is needed to be filled." Interview; on August 25, 2011 at 12:00 p.m.; with LPN #1 and LPN #2 [nurses on unit resident B resided] indicated the		on August 4, 2011, and it was faxed to pharmacy by nursing at that time. On 8-5-11, pharmacy faxed back to the facility for a clarification. This fax was not seen by nursing until 8-8-11, and physician was called at this time for clarification. From 8-9-11 to 8-15-11, nursing staff called MD to get clarification, and left messages, but they failed to document this. On 8-16-11, the pharmacy called again to get clarification. They waited eleven days to notify facility they still didn't have it. On 8-22-11, the Doctor's Office was called twice before finally receiving clarification. Pharmacy was notified that day, but had to back order Vicks Vapo Rub and treatment started on Resident B's toenail at this time. There was no consequences to resident due to delay. The facility policy was not followed on clarifications of physician orders. To prevent and ensure that resident B, and all other residents receive orders on a timely basis an inservice was held on 8-15-11 on tracking new medication orders (see attached #4 & 5).Monitored by: D.O.N., A.D.O.N., Administrator and QA Committee***REVISIONMedicatio ns orders will be monitored daily by A.D.O.N. to ensure follow-up is done timely for all orders. A.D.O.N. will report any orders not completed to Administrator and D.O.N. in morning meetings to ensure completion. All	

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	pharmacy had requested the clarification because the orders, as written were unclear. Documentation dated August 22, 2011 [time not documented] indicated the Physician's orders dated August 04, 2011; had been clarified and the prescribed medications had been delivered to the nursing facility. Medication Administration Records dated August 01, 2011 through August 31, 2011; indicated Resident B had received the initial treatment of Fungnail Tincture, Fungi-nail, and Vicks Vapor Rub on August 23, 2011; during the 6:00 a.m. to 2:00 p.m. shift. The facility's Policy and Procedure for Physician Orders [non-dated] provided by the Director of Nursing on August 30, 2011 indicated; "Purpose: To ensure all physician orders are initiated and followed through. Procedure: 1. A duplicate copy of all new physician orders obtained during each shift will be attached to the 24 hour report sheet. 2. All new orders will be wrote down on the 24 hour report sheet. ... 4. If there is no call back for clarifications ... the initial nurse to inform oncoming shift to follow through. The oncoming shift to follow up with call to doctor and if still no return calls notify		incidents will be investigated thoroughly, and brought to the monthly Q.A. Committee Meeting for further investigation.Monitored by: D.O.N., A.D.O.N., Administrator and QA Committee	

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	the Director of Nursing , and/or Assistant Director of Nursing. The Medical Director, Director of Nursing, and/or Assistant Director of Nursing will be notified if no return call with in 24 hours. ... 5. Daily report sheets will be obtained by an administrative nurse after morning report to be reviewed for accuracy and follow up as needed. Interview on August 25, 2011 at 2:15 p.m.; the Director of Nursing indicated she had not received the pharmacy's request for clarification. A medication clarification should have been done with-in 24 hours; to initiate prompt treatment for the diagnosed Fungi toenail. This deficiency is related to Complaint IN00095253. 3/1-37(a)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interviews and record reviews, the facility failed to ensure prompt	F0315	An order for a UA/C & S for resident E was received on 8-1-11. Urine sample was	09/16/2011

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	treatment of a diagnosed urinary tract infection for 1 of 3 residents reviewed for appropriate care and services of bladder function in a sample of 11 residents. (Resident E) Findings include: 1. Resident E's clinical records were reviewed on August 25, 2011 at 2:30 p.m. Physician's orders dated August 01, 2011 at 9:30 a.m.; indicated for staff to obtain a urinalysis [a laboratory test for analysis of urine] with culture and sensitivity [susceptibility and/or resistance to antibiotics of identified microorganisms], due to a possible diagnosis of an urinary tract infection. Nurse's Notes indicated; "8-2-11 0530 [5:30 a.m.] UA [urinalysis] and C&S [culture and sensitivity] obtained @ this time. ..." A Microbiology and Molecular Testing report dated August 05, 2011 indicated; "Source: Urine. Collected: 08/02/11 05:30. Received: 08/02/11 15:21 [3:21 p.m.]. Urine with Colony Count Culture - Isolate: 01 Escherichia coli 100,000 CFU/mL [volume of identified bacteria in urine]. A list of antibiotics the identified bacteria is resistant to, was printed on the		collected at 5:30 on 8-2-11. The U/A results testing was faxed to the physician on the same day at 15:21 (3:21 pm). On 8-3-11, C & S results were faxed, scant growth observed, culture re-incubated. On 8-4-11, C & S results were received from Med Lab. The night shift nurse did not pass it on that they were received. Instead, she charted not received, and there was "no odor, temperature of 97.6, and denies pain." This was charted on 8-3-11, 8-4-11, & 8-5-11 (see attached #6). The night shift supervisor, RN #7, was the previous D.O.N., and definately knew the policy on reporting unreturned labs to the D.O.N. She had received a written write-up and suspension for not following an abuse policy earlier that month. Resident E had no signs and symptoms of pain or discomfort during this time. (see attached #'s 6 & 7). On 8-8-11, the day shift nurse who had been off returned and noticed we didn't have lab results, and immediately called the lab for results (see attached #7). Labs were faxed to the facility at 10:00 on the same day and faxed to physician when received for orders. Physician did not return a call to the facility until 8-11-11 with orders. The resident still not complaining of pain at this time (see attached #7). The facility policy on reporting of labs to the physician was not followed by these few nurses. It is not the	

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	report. Continued review of Nurse's Notes indicated on August 11, 2011 [time not documented] Resident E's attending physician had received the Microbiology and Molecular Testing report dated August 04, 2011. Physician Orders dated August 11, 2011 [time not documented]; indicated Nitroforantoin, an antibiotic, for treatment of the diagnosed urinary tract infection had been implemented/started. Medication Administration Records dated August 01, 2011 through August 31, 2011; indicated Resident E received the initial/first dose of Nitroforantoin on August 11, 2011 at 8:00 p.m. The facility's Policy and Procedure for Physician Orders [non-dated] provided by the Director of Nursing on August 30, 2011 indicated; "Purpose: To ensure all physician order's are initiated and followed through. Procedure: 1. A duplicate copy of all new physician orders obtained during each shift will be attached to the 24 hour report sheet. 2. All new orders will be wrote down on the 24 hour report sheet. ... 4. If there is no call back for ... abnormal labs ... the initial nurse to inform oncoming shift to follow through.		normal function of this facility. To ensure resident E and all residents of Meadows East receive timely orders on labs, an inservice was held on 9-15-11 (see attached #'s 4 & 5). The D.O.N. also will continue to track all labs on timeliness of results.Monitored by: Administrator, D.O.N., A.D.O.N., and QA Committee***REVISIOND.O.N is now tracking U/A C&S daily to ensure all orders are followed in a timely manner. She will report to Administrator and A.D.O.N. in morning meeting on any discrepency in orders. All discrepincies will be brought monthly QA meetings. Monitored by: Administrator, D.O.N., A.D.O.N., and QA Committee	

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	The oncoming shift to follow up with call to doctor and if still no return calls notify the Director of Nursing , and/or Assistant Director of Nursing. The Medical Director, Director of Nursing, and/or Assistant Director of Nursing will be notified if no return call with in 24 hours. ... 5. Daily report sheets will be obtained by an administrative nurse after morning report to be reviewed for accuracy and follow up as needed. The Director of Nursing was interviewed on August 29, 2011 at 2:15 p.m. During the interview the Director of Nursing indicated Resident E's physician received the results of the Microbiology and Molecular Testing results dated August 05, 2011; on August 11, 2011. The physician should have received notification of the urinalysis results on August 05, 2011; to initiate prompt treatment for the diagnosed urinary tract infection. This deficiency is related to Complaint IN00095253. 3.1-41(a)(2)			
F0505 SS=D	The facility must promptly notify the attending physician of the findings. Based on interviews and record reviews the facility failed to ensure an urinalysis	F0505	Meadows Manor East does notify physicians of lab results on a	09/16/2011

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	laboratory result had been promptly reported to a resident's attending physician for 1 of 3 residents reviewed for prompt reporting of laboratory results in a sample of 11 residents. (Resident E) Findings include: Resident E's clinical records were reviewed on August 25, 2011 at 2:30 p.m. Physician's orders dated August 01, 2011 at 9:30 a.m.; indicated for staff to obtain an urinalysis [a laboratory test for analysis of urine] with culture and sensitivity [susceptibility and/or resistance to antibiotics of identified microorganisms], due to a possible diagnosis of an urinary tract infection. Nurse's Notes indicated; "8-2-11 0530 [5:30 a.m.] UA [urinalysis] and C&S [culture and sensitivity] obtained @ this time. ..." A Microbiology and Molecular Testing report dated August 05, 2011 indicated; "Source: Urine. Collected: 08/02/11 05:30. Received: 08/02/11 15:21 [3:21 p.m.]. Urine with Colony Count Culture - Isolate: 01 Escherichia coli 100,000 CFU/mL [volume of identified bacteria in urine]. A list of antibiotics the identified bacteria is resistant to, was printed on the		timely basis. This F-tag is a rare occurrance for this facility, and occurred because a few nurses did not follow the policy. Resident E was monitored during the lapse time period, and showed no signs and symptoms of discomfort (see attached #'s 6 & 7). The U/A was faxed timely, but the C & S had to be reincubated with results faxed at a later date. The results were not reported to the D.O.N. or physician as per policy. To prevent this F-tag from reoccurring to resident E and all other residents of this facility, an inservice was held on 9-15-11 on reporting lab results to physicians (see attached #5).Monitored by: D.O.N., Administrator and Q.A. Committee***REVISIOND.O.N. will monitor U/AC&S daily to monitor lab results and Dr. notification. Labs not received or reported to physcians will be done immediately and reported to the Administrator daily and monthly in Q.A. commitee.Monitored by: D.O.N., Administrator and Q.A. Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 00 B. WING	08/30/2011

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	report. Continued review of Nurse's Notes indicated on August 11, 2011 [time not documented] Resident E's attending physician had received the Microbiology and Molecular Testing report dated August 04, 2011. An antibiotic [Nitroforantoin] for treatment of a diagnosed urinary tract infection had been implemented/started. The facility's Policy for Tracking Labs Obtained and Lab Results dated January 14, 2007; provided by the Director of Nursing on August 29, 2011; indicated "The following will be attached to the daily report sheet by each charge nurse on each shift: 1. A duplicate copy of all new physician orders obtained during each shift. 2. A duplicate copy of labs obtained during each shift. 3. The temporary copy of all lab results received during each shift. The oncoming charge nurse will be responsible to: ... 3. All labs obtained duplicates (the white copies) are to be attached to daily report sheet to ensure that all labs are obtained as ordered. ... 4. Lab results are to have a copy of physician fax sheet notification attached and/or written notification on the lab result sheet that physician has been notified. If no fax is attached, or no written notification that physician has been notified, the oncoming			

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	nurse is responsible to see that the physician is notified either by fax and/or oral report. ..." The Director of Nursing was interviewed on August 29, 2011 at 2:15 p.m. During the interview the Director of Nursing indicated Resident E's physician had received the results of the Microbiology and Molecular Testing results dated August 05, 2011; on August 11, 2011. The physician should have received notification of the urinalysis results on August 05, 2011; as indicated by the facility's policy and procedure. This deficiency is related to Complaint IN00095253. 3.1-49(f)(2)			